Coronial Checklist

Summary The document is an Information Bulletin to advise that a Coronial Checklist is now available.

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Distributed to Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Audience Administration;Clinical;Nursing;Emergency Dept staff

CORONIAL CHECKLIST

PURPOSE

To advise the NSW health system of a checklist that has been drawn up for use in determining whether a death should be reported to the coroner.

KEY INFORMATION

The NSW Health Department has recently issued Policy Directive PD2010_054 Coroners Cases and the Coroners Act 2009. A Coronial Checklist has been developed for optional use as an aid in determining whether a death should be reported to the coroner. All forms (those annexed to the Policy Directive PD2010_054 and the Coronial Checklist) can be obtained from SALMAT either by Electronic Print On Demand (ePOD) or by purchase order from Health Support Services, Better Health Centre.

ATTACHMENTS

1. Coronial Checklist

NSW HEALTH

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

Facility:

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CORONIAL CHECKLIST

SMR010513

Deaths Reportable to the Coroner – check list

This checklist is to be used to determine if a death should be reported to the coroner. It is to be completed by the officer determining extinction of life for all patients (PD 2005_488). The form is filed in the front of the medical record.

This check list is to be used in conjunction with NSW Health Policy Directive 'Coroners Cases and the Coroners Act' http://www.health.nsw.gov.au/policies/pd2010_054

Coronial Flags	YES	NO
1. Did the person die a violent or unnatural death?		
2. Did the person die a sudden death, the cause of which is unknown?		
3. Did the person die under suspicious or unusual circumstances?		
4. Did the person die in circumstances where the person **HAD NOT** been attended by a medical practitioner during the period of six months immediately before the person's death?		
5. Did the person die in circumstances where death **WAS NOT** the reasonably expected outcome of a health related procedure carried out in relation to that person? *(see point 1 over page for further guidance)*		
6. Did the person die while in or temporarily absent from a declared mental health facility and while the person was a resident at the facility for the purpose of receiving care, treatment or assistance? (includes admission to acute care facility whilst a patient of a Mental Health Facility)		
7. Did the person die whilst in the custody of a police officer or in other lawful custody? *(see point 2 over page for further guidance related to deaths in custody)*		
8. Did the person die whilst escaping or attempting to escape from the custody of a police officer or other lawful custody?		
9. Did the person die as a result of, or in the course of police operations?		
10. Did the person die whilst temporarily absent from an institution or place where the person was an inmate?		
11. Was the person a child in care, or a child whose death is or may be due to abuse or neglect or that occurred in suspicious circumstances? *(see point 3 over page for definitions and guidance related to death of a child)*		
12. Was the person (child or adult) living in or temporarily absent from, residential care provided by a service provider and authorised or funded under the Disability Services Act 1993 or a residential centre for disabled persons? *(see point 3 (e) over page for definitions and guidance)*		
13. Was the person disabled within the meaning of the Disability Service Act 1993 and receiving from a service provider assistance to enable them to live independently in the community? *(see over page point 3 (f) for definitions and guidance)*		

If answers to ALL of the questions are NO, the death is NOT required to be referred to the Coroner and a death certificate MAY be issued. Where doubt exists as to whether a death should be reported, telephone the Duty Pathologist (**Glebe:** *Business Hours (02) 8584 7821, After Hours (02) 8584 7821.* **Northern Forensic Hub, Newcastle:** *Business Hours (02) 4922 3700, After Hours (02) 49290822)* for clarification. The State Coroner's Court may also be contacted for advice on (02) 8584 7777.

If the answer is YES to ANY question the death must be referred to the Coroner using S*MR010.510 – Reporting of Death of a Patient to the Coroner* and a death certificate MUST NOT be issued.

The exception to this rule is that under S38 (2) of the Act, medical practitioners can issue a death certificate if they are of the opinion that the person:
(a) was aged 72 years or older, and
(b) died in circumstances other than in any of the circumstances referred to above, and
(c) died after sustaining an injury from an accident, being an accident that was attributable to the age of the person, contributed substantially to the cause of death and was not caused by an act or omission by any other person(this applies to accidents at home or in institutions)

However the medical practitioner **must state** on the certificate that it is given in pursuance of *S38(2) of the Coroners Act 2009*. A medical practitioner cannot certify the cause of death in accordance with this section if before the certificate is given a relative of the deceased person indicates to the medical practitioner that s/he objects to the giving of the certificate. If an objection by a relative occurs the death must be reported to a police officer who is then required to report the death to a coroner or assistant coroner as soon as possible after the report is made.

Staff Name: Signature: Designation: Date:

NSW HEALTH

Facility:

CORONIAL CHECKLIST

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

The following are extracts from NSW Health Policy Directive 'Coroner's Cases and the Coroners Act 2009.' PD2010_054

1. **NSW Health Guidelines Regarding Whether a Death is a Reasonably Expected Outcome of a Health Related Procedure**

The NSW Coroner's Act does not define the term '*reasonably expected outcome*', this is a matter for medical practitioners to decide based upon the facts of the case. '*Health related procedure'* is defined in the Act. Guidelines to assist the medical practitioner determine whether or not the death should be reported to the coroner are below:

(i). Is the death a reportable death? Consider:
- did the health related procedure cause the death?
- was the death an unexpected outcome?

If the answer to both of these questions is yes, then the death is reportable.

(ii). Did the health related procedure cause the death? Consider:
- was the health related procedure necessary to improve the patient's medical condition, rather than an elective or optional procedure?
- was the health related procedure performed in a manner, which at the time of the death, would be considered by your peers as competent professional practice?

If the answer to both of these questions is yes, then the death may not be reportable.

(iii). Was the death an unexpected outcome of the health related procedure? Consider:
- whether the patient's condition (factoring in their age and co-morbidities) at the time they underwent the health or health related procedure was such that death was likely to occur if they did not undergo the procedure?
- was death recognised as being a significant risk of the procedure given the patient's medical condition, but the patient, family and/or medical practitioner believed the potential benefits of the procedure outweighed the risk?
- whether the health related procedure was performed in a manner which at the time of the death, would be considered by your peers as competent professional practice?

If the answer to each of these questions is yes, then the death may not be reportable.

The factors to consider in each particular case will be different and doctors should use their professional judgement to determine whether the death is reportable. If the medical practitioner is uncertain about whether the death is reportable then s/he should contact the NSW State Coroner's Office on (02) 8584 7777 or the Duty Pathologist (**Glebe:** *Business Hours (02) 8584 7821, After Hours (02) 8584 7821.* **Northern Forensic Hub, Newcastle:** *Business Hours (02) 4922 3700, After Hours (02) 49290822*).

Health related procedure: Health related procedure means a medical, surgical, dental or other health related procedure (including the administration of an anaesthetic, sedative or other drug)

2. **Deaths in Custody**

A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died (or that there is reasonable cause to suspect that the person has died):
(a) while in the custody of a police officer or in other lawful custody, or
(b) while escaping, or attempting to escape, from the custody of a police officer or other lawful custody, or
(c) as a result of, or in the course of, police operations, or
(d) while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate:
(i) a detention centre within the meaning of the *Children (Detention Centres) Act 1987*,
(ii) a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*,
(iii) a lock-up, or
(e) while proceeding to an institution or place referred to in paragraph (d), for the purpose of being admitted as an inmate of the institution or place and while in the company of a police officer or other official charged with the person's care or custody.

3. **Death of a Child and/or a Disabled Person**

A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person was (or that there is reasonable cause to suspect that the person was):
(a) a child in care, or
(b) a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* within the period of 3 years immediately preceding the child's death, or
(c) a child who is a sibling of a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons Care and Protection) Act 1998* within the period of 3 years immediately preceding the child's death, or
(d) a child whose death is, or may be due to abuse or neglect or that occurs in suspicious circumstances, or
(e) a person (whether or not a child) who, at the time of the person's death, was living in, or was temporarily absent from, residential care provided by a service provider and authorised or funded under the *Disability Services Act 1993* or a residential centre for disabled persons, or
(f) a person (other than a child in care) who is in a target group within the meaning of the *Disability Services Act 1993* who receives from a service provider assistance (of a kind prescribed by the regulations) to enable the person to live independently in the community.

NO WRITING